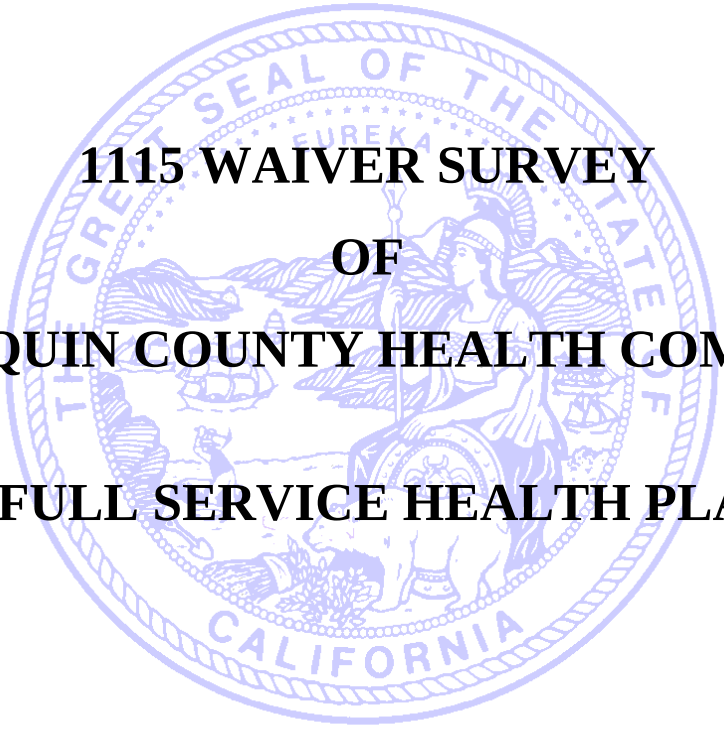
DEPARTMENT OF
Managed
Health Care
Help Center

DIVISION OF PLAN SURVEYS

1115 WAIVER SENIORS AND PERSONS WITH DISABILITIES (SPD) ENROLLMENT SURVEY

SURVEY REPORT
FOR THE
DEPARTMENT OF HEALTH CARE SERVICES



1115 WAIVER SURVEY

OF

SAN JOAQUIN COUNTY HEALTH COMMISSION

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: JUNE 19, 2012

1115 Waiver Survey Report of the SPD Enrollment
San Joaquin County Health Commission
A Full Service Health Plan
June 19, 2012

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OF

SAN JOAQUIN COUNTY HEALTH COMMISSION

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: JUNE 19, 2012

EXECUTIVE SUMMARY

The California Department of Health Care Services ("DHCS") received authorization (1115 Waiver) from the Federal Government to conduct mandatory enrollment of seniors and persons with disabilities ("SPD") into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The Department of Managed Health Care ("the Department") entered into an Inter-Agency Agreement with the DHCS to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patient-rights laws. Mandatory enrollment began in June 2011.

On November 29, 2011, San Joaquin County Health Commission (the "Plan") was notified that its Medical Survey had commenced and was requested to provide the Department with the necessary pre-onsite data and documentation. The Department's survey team conducted the onsite portion of the Medical Survey from February 21, 2012 through February 23, 2012.[1] The Department completed its information gathering and closed the survey on March 22, 2012.

SCOPE OF SURVEY

Based on the scope of work defined in the Department's Inter-Agency Agreement (Agreement Number 10-87255) approved September 20, 2011 with DHCS, the SPD enrollment medical survey focused on the following areas:

I. Utilization Management

[1] Pursuant to the Knox-Keene Health Care Service Plan Act, codified at Health and Safety Code section 1340, *et seq.*, Title 28 of the California Code of Regulations section 1000, *et seq.* and the Department of Health Care Services Two-Plan and GMC Boilerplate Contracts. All references to "Section" are to the Health and Safety Code unless otherwise indicated. All references to the "Act" are to the Knox-Keene Health Service Plan Act of 1975, contained in Health and Safety Code sections 1340, et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated. All references to "Contract" are to the Two-Plan or GMC Boilerplate contract issued by the Department of Health Care Services.

II. Continuity of Care

III. Availability and Accessibility

IV. Member's Rights

V. Quality Management

The scope of the survey incorporated review of health plan documentation and files from the period of November 1, 2010 through October 31, 2011.

SUMMARY OF FINDINGS

POTENTIAL DEFICIENCIES[2]

The Department identified **four** potential survey deficiencies relating to access and availability and member rights during the current Medical Survey.

In the Department's review of the Plan's adherence to MMCD Policy Letters 11-009 & 11-013, and pursuant to Welfare and Institutions Code section 14182(b)(9), the Plan does not consistently publish the access level and the provider accessibility indicators on their Web site and in Provider Directories.

The Department identified a potential deficiency in the area of access and availability. The Plan has not adopted the 1:1200 enrollee to provider ratio in its access and availability policies and does not use this measure in assessing the adequacy of its provider network.

The Department's review of SPD member grievances confirmed that in some instances, the Plan prematurely closes out enrollee grievances by sending a combined "acknowledgment and resolution" letter (Combined Letter) before the grievance is fully investigated and resolved.

Lastly, the Plan was unable to demonstrate that the grievance process considers the linguistic and cultural needs of SPD enrollees. Grievance acknowledgment and resolution letters lacked documentation informing SPD enrollees how to request language assistance or translation services. The sample of SPD grievance files did not consider cultural and linguistic issues as part of the grievance or offer the enrollee information to obtain language assistance.

[2] The Summary of *Findings and Potential Deficiencies* Section of this Report contain a discussion of these deficiencies and Appendix D contains the complete text of the relevant statutes, rules and contract language.

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD ENROLLEES

Beginning February 2011, the Plan began educating its contracted providers and facilities regarding the unique needs and challenges encountered by the SPD member population. The Plan trained its staff, conducted access surveys of provider offices, developed and/or revised case management policies and procedures, and instituted audits to gauge the adequacy of SPD enrollee needs assessments. The Plan has stratified and identified high risk factors among its SPD population. Developing programs to meet the needs of high-risk SPD members has been the Plan's priority. The Plan has conducted extensive outreach activities in order to identify, enroll and support eligible SPD individuals, including:

- The Plan's numerous provider outreach efforts have raised awareness and sensitivity in providing services to SPD enrollees. The Plan has educated providers on procedures to transition SPDs from Fee-For-Service to Managed Care and the services available to assist in coordinating care.

- The Plan conducted outreach to Fee-For-Service providers currently treating SPD enrollees requesting their assistance to help ensure continuity of care for SPD members who wish to keep their current Physician.

- The Plan evaluated its prescription drug formulary to determine if updates were necessary.

- The Plan conducted a physical assessment and modified its headquarters to ensure accessibility to SPD enrollees, and developed comprehensive Health Risk Assessment and Care Plans for each SPD.

- The Plan hired 3 medical assistants, Health Navigators, exclusively assigned to work with SPDs and trained all staff on "best practices" for assisting SPDs.

- The Plan designed a robust In-Home Care Program for SPDs and promoted a Home Health Transition Plan for SPD enrollees.

DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

SURVEY REPORT
1115 WAIVER SPD ENROLLMENT

SAN JOAQUIN COUNTY HEALTH COMMISSION

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: JUNE 19, 2012

PLAN SURVEY SCOPE

The Department and DHCS entered into an Inter-Agency Agreement (Agreement Number 10-87255) approved September 20, 2011 in which the Department agreed to perform medical surveys in conjunction with the provisions of the California Section 1115 Medicaid Demonstration Waiver entitled "Bridge to Reform."

The Department has completed a written summary of medical survey findings pursuant to the Inter-Agency Agreement and has identified potential deficiencies in Plan operations supporting SPD membership. This medical survey evaluated the following elements related to the Plan's delivery of care to the SPD population pursuant to the DHCS contract requirements and compliance with the Act:

I. Utilization Management
The Department evaluated Plan operations related to utilization management, including implementation of Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

II. Continuity of Care
The Department evaluated Plan operations to determine whether medically necessary services are effectively coordinated both inside and outside the network, to ensure the coordination of special arrangement services, and to verify that the Plan provides for completion of covered services by a non-participating provider when required.

III. Availability and Accessibility
The Department evaluated Plan operations to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes and addressing reasonable patient requests for disability accommodations.

IV. Member Rights

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician (PCP) selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

This Survey Report addresses the 1115 Waiver SPD Survey of the Plan, which commenced on November 29, 2011 and closed on March 22, 2012.[3]

[3] See Appendix A for the Timeline of Current Survey Activities

2012 SAN JOAQUIN COUNTY HEALTH COMMISSION: SURVEY FINDINGS AND POTENTIAL DEFICIENCIES

The Department identified potential deficiencies, by survey area:

UTILIZATION MANAGEMENT

Consistent with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's utilization management processes:

a. The development, implementation, and maintenance of a Utilization Management Program.
b. The mechanism for managing and detecting over and under-utilization of services.
c. The methodologies and processes used to handle prior authorizations appropriately while complying with the requirements specified in the contract as well as in State and Federal laws and regulations.
d. The methodologies and processes used to evaluate utilization management activities of delegated entities.

POTENTIAL DEFICIENCIES:
No potential deficiencies were identified in the area of utilization management.

CONTINUITY OF CARE

Consistent with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's continuity of care processes:

a. The methodologies and processes used to coordinate medically necessary services within the provider network.
b. The coordination of medically necessary services outside the network (specialists).
c. The coordination of special arrangement services including, but not limited to, California Children's Services, Child Health and Disability Prevention, Early Start and Regional Centers.
d. Compliance with continuity of care requirements in section 1373.96 of the Health and Safety Code.

POTENTIAL DEFICIENCIES:
No potential deficiencies were identified in the area of continuity of care.

AVAILABILITY AND ACCESSIBILITY

Consistent with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's processes to support access and availability:

a. The availability of services, including specialists, emergency, urgent care, and after hours care.
b. Health plan policies and procedures for addressing a patient's request for disability accommodations.

Potential Deficiency #1: The Plan does not consistently publish the access level and the provider accessibility indicators on their Web site and in Provider Directories.

Statutory/Regulatory/Contractual Reference:
DHCS MMCD Policy Letter 11-013
In accordance, with the Facility Site Review (Attachment C) MMCD Policy Letter 11-013 and pursuant to Welfare and Institutions Code section 14182(b)(9) the Plan is required to make the results of the FSR Attachment C available to members through their Web sites and Provider Directories. The information provided must at a minimum, display the level of access results met per provider site as either Basic Access or Limited Access. Additionally, health plans must indicate whether the site has Medical Equipment Access as defined in the FSR Attachment C and identify whether each provider site has or does not have access in the following categories: parking, building exterior, building interior, exam room, restroom and medical equipment (height adjustable exam table and patient accessible weight scales).

DHCS MMCD Policy Letter 11-009
Establishes policy and guidelines for use of standardized physical accessibility indicators in all provider directories to assist SPDs in locating physically accessible provider sites.

DHCS Two-Plan Contract, Exhibit A, Attachment 13 Member Services, Item 4 – Member information
4) Compliance with the following may be met through distribution of a provider directory: The name, provider number, address, and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), specialists, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, FQHCs, Indian Health Programs). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, provider number, address, and telephone number shall appear for each Physician provider: The hours and days when each of these facilities is open, the services and benefits available, including which, if any, non-English languages are spoken, the telephone number to call after normal business hours, accessibility symbols approved by DHCS, and identification of providers that are not accepting new patients.

Supporting Documentation:

- Plan's searchable online Provider Directory http://www.hpsj.com/english/members/providersearch.aspx
- PDF version of Medi-Cal Member Provider Directory, August 2011

Factual Findings: The Department found that the Plan's online searchable Provider Directory does not incorporate the required level of access information (Basic Access or Limited Access) or the accessibility indicators per provider site as required by the DHCS MMCD Policy Letters 11-013 and 11-009. Although the Plan's Medi-Cal Provider Directory (PDF version, August 2011) identifies the accessibility indicators, it does not include the level of access information at each provider site.

The Provider Directory is located in the "Our Plans" section of the Plan's Web site; however, the online searchable Provider Directory is in a different location in the "Member Corner." As a result, having two locations for the Provider Directory, with one searchable version, may create confusion for members and a barrier to locate and search the Provider Directory.

Comments on Findings: The Plan has updated the online PDF version of its Provider Directory to display the accessibility indicators of its provider sites, including specialist and ancillary service providers. However, the Plan needs to ensure that the required *level of access* and *accessibility indicator* information is included in the online and searchable Provider Directory, as well as in the printed versions of the Provider Directory. The Plan may also consider making the online PDF version of its Provider Directory available in the "Member Corner" for easy access.

Potential Deficiency #2: The Plan has not established an enrollee to provider ratio as specified in the Act and Contract.

Statutory/Regulatory/Contract Reference:
Rule 1300.67.2(d) states "The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;"

DHCS 2-Plan Contract, Exhibit A, Attachment 6 – Provider Network, Item 3: Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:
    1) Primary Care Physicians 1:2,000
    2) Total Physicians 1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients.

Supporting Documentation:

- Policy PR011- Monitoring Network Adequacy
- Policy PR008 - Monitoring Provider to Member Ratio

Factual Findings: Review of the Plan's "Monitoring Provider to Member Ratios" policy revealed the absence of an established written standard for the ratio of enrollees to Physicians within the Plan's provider network. During the onsite survey, the Plan presented Geo-Access Reports that reflect the Plan's geographic evaluation of the Plan's current network; however, the Plan had not established a standard enrollee to provider ratio to measure its performance. During the onsite survey, the Plan indicated that it is in the process of establishing the required standard.

Comments on Findings: While the Plan monitors and evaluates its access standards, the Plan does not have the requisite numerical standard established in its policy for enrollee to Physician ratios; specifically, specialty providers. The Plan should establish and publish the access standard in its policies so Plan staff can evaluate the ratios and geographic dispersion of available specialist providers in the Plan's network. This will allow the Plan to identify possible access issues and make appropriate adjustments to its network, if necessary. The absence of a formal standard for enrollee to provider ratio hinders the Plan from quantitatively evaluating the scope of its network.

MEMBER RIGHTS

Consistent with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's Member Right's processes:

a. Compliance with requirements for a complaint/grievance system. Examine a sufficient number of SPD member grievance files to ensure an appropriate audit confidence level.
b. PCP selection and assignment requirements.
c. Interpreter services and member informing materials available in identified threshold languages.
d. The health plan's ability to provide communication access to SPDs in alternative formats or through other methods that ensure communication.

Potential Deficiency #3: The Plan does not consistently send a written resolution letter to enrollees at an appropriate time within the 30 day grievance process.

Statutory/Regulatory/Contract Reference:
Section 1368(a)(1) states "Each [grievance] system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate."

Section 1368(a)(4)(A) states that plans shall "Provide for a written acknowledgment within five calendar days of the receipt of the grievance…"

Section 1368(a)(5) states that plans shall "provide subscribers and enrollees with written responses to grievances with a clear and concise explanation of the reasons for the plan's response."

Rule 1300.68(a)(4) states "resolved means that the grievance has reached a final conclusion."

Rule 1300.68(d)(3) states "…a written response to the grievance shall be sent…within thirty (30) calendar days of receipt…"

DHCS Two-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System, Item 1. Contractor shall implement and maintain a Member Grievance System in accordance with Title 28 CCR, sections 1300.68 and 1300.68.01, Title 22 CCR section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

Supporting Documentation:
- SPD Grievance Log from 11/1/10 to 10/31/11
- Sample of 49 SPD Grievance files
- Plan's "Acknowledgment and Resolution" letters
- Plan's Grievance and Appeals Policy and Procedures

Factual Findings: The Plan's grievance policies are consistent with regulatory requirements which provide for an acknowledgement letter within 5 days of receipt of a grievance and the review and resolution of standard grievances within 30 calendar days.

The file review confirmed that in some instances a combined "acknowledgment and resolution" (Combined Letter) was sent to the enrollee and the case was appropriately resolved within 5 days. However, the Department identified other cases in which the Plan prematurely closed the enrollee's grievance and sent the combined acknowledgment and resolution letter. In these cases, the Plan's investigation went beyond 5 days, however, the Plan's 5 day closing letter had been sent to the enrollee.

The Department's review of 24 out of 49 SPD grievances showed the Plan continued its investigation of the enrollee's complaint after the 5 day resolution letter was sent. In these instances, the Plan's Combined Letter stated,

> *"Your concern regarding [X] was forwarded to the Quality Improvement Department. You may hear from them directly. The Quality Improvement Department will continue to address, monitor, report, and record."*

However, the Plan continued to review, research, and evaluate the issue brought forth by the enrollee and in some cases contacted members by telephone to obtain additional information. In these cases, the Plan's combined letter did not constitute the formal resolution of the grievance. A formal written resolution to the enrollee is required upon the completion of the Plan's investigation on or before 30 days.

An acknowledgment letter is required within 5 days of receipt of an enrollee grievance. The acknowledgement letter does not serve as a resolution to the grievance in situations in which the investigation will take longer than 5 days. The Plan should not close out the issue by combining the acknowledgment and resolution letter until the issue has been fully investigated and the Plan has completed a resolution to the complaint.

Relevant File Review: The Plan processed a total of 150 SPD grievance and appeal cases for the survey review period, and the Department reviewed a sample of 49 files.[4] The Department's review showed that in 24 out of 49 files, the investigation took longer than 5 days; however, the enrollee received the Plan's combined letter within 5 days of receipt of the grievance. As result, in 24 out of 49 files, the plan did not provide the enrollee a written resolution that is consistent with rule 1300.68(a)(4).

Comments on Findings: This potential deficiency will require the Plan to restructure the grievance process to issue an acknowledgement letter within 5 days of receipt, however, as necessary, continue to investigate and consider all of the issues raised in the grievance in order to reach a final conclusion.

The Plan is correct in sending out a written acknowledgment letter within five calendar days of receipt in accordance with section 1368(a)(4)(A). The Plan's process fails when the Plan issues a combined letter, closes the grievance, however, continues to investigate the issues beyond the 5 days. The enrollee is entitled to a grievance resolution letter when the Plan has reached a final conclusion, within a 30 day timeframe.

If the enrollee's grievance is properly resolved within 5 days, the Plan's combined letter can be sent to the enrollee describing the Plan's resolution in a clear and concise manner in accordance with section 1368(a)(5) of the Act. However, if the issues raised in the grievance require an investigation that takes longer than 5 days, the Plan should not send out a resolution letter until all research and investigation by the Plan is complete. In these circumstances, the Plan should issue two separate letters; 1) a grievance acknowledgement letter and 2) grievance resolution letter at the completion of the investigation.

The research, investigation and resolution concerning the enrollee's grievance must be completed in 30 calendar days as described in rule 1300.68(a)(4)(A). Once the grievance is

[4] November 1, 2010 through October 31, 2011

resolved within the meaning of rule 1300.68(a)(4), the Plan should communicate the outcome of the grievance in written resolution letter as outlined in section 1368(a)(5) and rule 1300.68 (d)(3).

Potential Deficiency #4: The Plan was not able to demonstrate that the grievance system addresses linguistic and cultural needs of the SPD enrollees.

Statutory/Regulatory/Contractual Reference:
Rule 1300.68(b)(3) provides that the Plan's grievance system shall address the linguistic and cultural needs of its enrollee populations.

DHCS Two-Plan Contract, Exhibit A, Attachment 9 – Access & Availability, Item 14 Linguistic Services.

A. Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph D of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

B. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential members: 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages. 2) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's Service Area, and by the Contractor in its group needs assessment.

Supporting Documentation:

- SPD Grievance Log from 11/1/10 to 10/31/11
- Sample of 49 SPD grievance files
- Plan's "acknowledgment/resolution" resolution letters
- C& L Policy 09: Notification of Language Assistance Program (Member & Provider)

Factual Findings: The Plan's cultural and linguistic policy is consistent with regulations and requires that notice be provided to SPD enrollees regarding the availability of language assistance. The Department reviewed a sample of 49 SPD grievances and 52 Medi-Cal grievances. All of the files lacked the required notice of available assistance for language services. The Department noted, however, that 18 Healthy Family case files included the required language assistance notice, while case files of Medi-Cal and SPD enrollees did not.

Relevant File Review: The Plan processed a total of 150 SPD grievance and appeals cases for the survey review period, the Department reviewed a sample of 49 grievance and appeals cases submitted by SPD members.[5]

Comments on Findings: This potential deficiency requires the Plan include the notice of the availability of language assistance services in all grievance correspondence and for all product lines.

QUALITY MANAGEMENT

Consistent with the DHCS – DMHC Inter-Agency Agreement, the Department evaluated the Plan's Quality Management processes:

a. Evaluate the Plan's process to monitor, evaluate, identify problems, and take effective action to improve quality of care.
b. The Plan must establish a system of accountability for quality within the organization.
c. The Plan remains accountable and must conduct oversight of quality improvement activities that are delegated to its contracted provider entities.

POTENTIAL DEFICIENCIES:
No potential deficiencies were identified in the area of quality management.

[5] For the period November 1, 2010 through October 31, 2011.

DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

SURVEY REPORT
SPD ENROLLMENT MEDICAL SURVEY

OF

SAN JOAQUIN HEALTH COMMISSION

A FULL SERVICE HEALTH PLAN

APPENDICES

A P P E N D I X A

C. FILE REVIEW

Note: The statistical methodology utilized by the Department is based on an 80% Confidence Level with a margin of error of 7%. Each file review criterion is assessed at a 90% compliance rate.

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
SPD Grievances and Appeals	49	The Department identified the sample size based upon its standard File Review Methodology and a file universe of 150
Medi-Cal Grievances and Appeals	52	The Department identified the sample size based upon its standard File Review Methodology and a file universe of 210

A P P E N D I X B

D. APPLICABLE STATUTES, REGULATIONS, AND CONTRACT LANGUAGE

Section 1368(a)(1)
(a) Every plan shall do all of the following:
(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Section 1368(a)(4)(A)
(a) Every plan shall do all of the following:
(4)(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:
(i) That the grievance has been received.
(ii) The date of receipt.
(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

Section 1368(a)(5)
(a) Every plan shall do all of the following:
(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

Rule 1300.67.2(d)
(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

Rule 1300.68(a)(4)

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

(2) "Complaint" is the same as "grievance."

(3) "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

(4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

(A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.

(B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

Rule 1300.68(b)(3)

(b) The plan's grievance system shall include the following:

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.

Rule 1300.68(d)(3)

(d) The plan shall respond to grievances as follows:

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in Subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision.

Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

DHCS MMCD Policy Letter 11-009
Establishes policy and guidelines for use of standardized physical accessibility indicators in all provider directories to assist SPDs in locating physically accessible provider sites.

DHCS MMCD Policy Letter 11-013
In accordance, with the Facility Site Review (Attachment C) MMCD Policy Letter 11-013 and pursuant to Welfare and Institutions Code section 14182 (b)(9) the Plan is required to make the results of the FSR Attachment C available to members through their websites and provider directories. The information provided must, at a minimum, display the level of access results met per provider site as either Basic Access or Limited Access. Additionally, health plans must indicate whether the site has Medical Equipment Access as defined in the FSR Attachment C and identify whether each provider site has or does not have access in the following categories: parking, building exterior, building interior, exam room, restroom and medical equipment (height adjustable exam table and patient accessible weight scales).

DHCS 2-Plan Contract, Exhibit A, Attachment 6 – Provider Network, Item 3: Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:
    1) Primary Care Physicians 1:2,000
    2) Total Physicians 1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients.

DHCS Two-Plan Contract, Exhibit A, Attachment 13 - Member Services, Item 4 – Member information
4) Compliance with the following may be met through distribution of a provider directory: The name, provider number, address and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), specialists, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, FQHCs, Indian Health Programs). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, provider number, address and telephone number shall appear for each physician provider: The hours and days when each of these facilities is open, the services and benefits available, including which, if any, non-English languages are spoken, the telephone number to call after normal business hours, accessibility symbols approved by DHCS, and identification of providers that are not accepting new patients.

DHCS Two-Plan Contract, Exhibit A, Attachment 14 – Member Grievance System
1. Member Grievance System
A. Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).

Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

A. Procedure to ensure timely acknowledgement, resolution, feedback to complainant. Provide oral notice of the resolution of an expedited review.
B. Procedure to ensure a Member is given reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and a toll-free number with TTY/TDD and interpreter capability.

DHCS Two-Plan Contract, Exhibit A, Attachment 9 – Access & Availability, Item 14 Linguistic Services.

A. Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph D of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

B. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential members: 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages. 2) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's Service Area, and by the Contractor in its group needs assessment.

Welfare and Institutions Code section 14182(b)(9)

In exercising its authority pursuant to subdivision (a), the department shall do all of the following: Develop and provide managed care health plans participating in the demonstration project with a facility site review tool for use in assessing the physical accessibility of providers, including specialists and ancillary service providers that provide care to a high volume of seniors and persons with disabilities, at a clinic or provider site, to ensure that there are sufficient physically accessible providers. Every managed care health plan participating in the demonstration project shall make the results of the facility site review tool publicly available on their Internet Web site and shall regularly update the results to the department's satisfaction.